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No. 90-97

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

On Petition For A Writ Of Certiorari To The United States Court of Appeals For The Seventh Circuit

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AMICUS CURIAE BRIEF OF THE MARYLAND HOSPITAL ASSOCIATION, INC.

JOHN G. KRUCHKO*
PAUL M. LUSKY
KRUCHKO & FRIES
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204
(301) 321-7310

Attorneys for Amicus Curiae
The Maryland Hospital
Association, Inc.

* Counsel of Record

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I. INTEREST OF THE AMICUS CURIAE

The Maryland Hospital Association, Inc. submits its brief as *amicus curiae* in support of the Petitioner, the American Hospital Association.[1] The Maryland Hospital Association, Inc. ("MHA") is a private non-profit membership organization which has as its primary focus assistance to its member institutions in providing efficient high quality health care in Maryland. The MHA serves as a forum for communication and cooperation among health care providers in Maryland.

[1] All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

The MHA has fifty-three acute care hospital members representing all the acute care hospitals located in the State of Maryland. App., *infra*, 5a-9a. Its members include large metropolitan hospitals and small rural hospitals. The complexity of services offered in each hospital also varies. Some hospitals are community hospitals providing general care, while others provide tertiary level care in a number of specialty areas. Some of the acute care hospital members of the MHA have psychiatric or mental health units in their facilities while others combine acute care with long-term rehabilitative care.

The largest acute care hospital member of the MHA is The Johns Hopkins Hospital ("Johns Hopkins") located in Baltimore, Maryland, with over 6,000 employees and 1,036 beds. Equally representative of the membership of the MHA, however, is Kent & Queen Anne's Hospital, a small rural hospital in Chestertown, Maryland, with approximately 300 employees and 64 beds. All acute care hospital members of the MHA are subject to the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry ("Final Rule" or the "Rule"). 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30 (1989). Thus, all acute care hospital members of the MHA have a vital interest in the American Hospital Association's challenge to the Final Rule promulgated by the NLRB.

Eleven of the private acute care hospital members of the MHA have employees who are represented by unions. App., *infra*, 10a-12a. These hospitals have experienced the substantial costs associated with negotiating and administering collective bargaining agreements with unions. Four acute care hospital members of the MHA are currently involved in representation proceedings before the Board. On March 10, 1989, the Maryland Nurses Association ("MNA") filed a petition with the NLRB, designated Case No. 5-RC-13206, seeking to represent a unit of approximately 600 registered nurses at Greater Baltimore Medical Center ("GBMC"). The hospital has proposed, as an alternative bargaining unit, an all professional unit which would include numerous other allied health professionals at the hospital. Although a hearing was begun on the issue of the appropriate bargaining unit at GBMC, a ruling on this issue was put on hold by the injunction issued in this case by the United States District Court for the Northern District of Illinois. The United States Court of Appeals for the Seventh Circuit vacated the injunction against enforcement of the Board's Final Rule

on April 11, 1990. The American Hospital Association gained a stay of the court of appeals' order pending this Court's ruling on the petition for a writ of certiorari. The writ of certiorari was granted on October 9, 1990.

A representation proceeding between Peninsula General Hospital Medical Center ("Peninsula General") and the MNA has also been curtailed by the injunction issued by the district court in this case. The MNA seeks to represent a unit of all technical employees at Peninsula General. The hospital, however, seeks to have the NLRB certify a broader unit of all nonprofessional employees. No decision has been issued on this petition, designated Case No. 5-RC-13355 by the NLRB.[2]

If the decision of the Seventh Circuit is not reversed, however, it is expected that Region 5 of the NLRB will move quickly to apply the Board's Final Rule to the petitions filed at GBMC and Peninsula General. It is expected that the Region will certify the proposed unit of registered nurses as an appropriate bargaining unit at GBMC without considering the special circumstances of employment at the hospital. Similarly, the Region will also approve the proposed unit of technical employees at Peninsula General without considering whether an all nonprofessional unit is the appropriate bargaining unit for Peninsula General employees. If the Seventh Circuit's decision is not reversed, both GBMC and Peninsula General will be precluded from exploring the appropriateness of alternative bargaining units in response to the petitions filed by the MNA.

Those hospitals which have been touched by union organizing or which face application of the Board's Final Rule to pending representation proceedings have relevant information to bring to bear on the question of the validity of a *per se* bargaining unit rule which would impose as many as eight bargaining units on health care

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[2] The other two hospitals involved in proceedings before the Board are Prince George's Hospital Center and Greater Laurel- Beltsville Hospital. District 1199E-SEIU has petitioned to represent technical employees in both hospitals. The petitioned- for unit has been treated as a residual unit by the Board because other technical employees at the hospitals are part of a service and maintenance unit represented by Local No. 63, International Brotherhood of Firemen and Oilers. *See* discussion, pp. 22-23, *infra*.

workplaces without affording hospitals any opportunity to be heard on the issue of the appropriateness of such units.

The Board's Final Rule ignores the differences between acute care hospitals in Maryland, differences which, in any particular case, make application of the Rule an arbitrary and capricious imposition on the rights of member hospitals of the MHA to deal with their employees over wages, hours and working conditions. The Board's Final Rule also ignores significant trends within acute care hospitals in Maryland including the development of integrated systems for delivery of health care to patients. The Rule fails to give recognition to the extensive interaction between registered nurses and other allied health professionals which is a natural outgrowth of these multidisciplinary approaches to patient care. The Board's Final Rule will only lead to increased disruption within Maryland hospitals and an increase in costs for acute care hospitals already struggling to meet budgetary constraints. The MHA is thus vitally interested in the issues presented by this case and it believes it can illuminate the disruption and associated costs that will be imposed on its acute care hospital members if the Seventh Circuit's decision vacating the injunction against the Rule is allowed to stand.

II. SUMMARY OF THE ARGUMENT

This case raises the issue of the NLRB's authority to promulgate and apply a rule mandating that only eight bargaining units are appropriate within acute care hospitals regardless of their size, location or differences in their operations. The MHA contends that the Board's Final Rule and its *per se* application to all representation petitions involving acute care hospitals is contrary to Section 9(b) of the National Labor Relations Act (the "Act")which requires the Board to decide appropriate bargaining units "in each case". 29 U.S.C. § 159(b). Further, the Final Rule is in conflict with the congressional admonition against proliferation contained in the legislative history of the Health Care Amendments Act of 1974.

The Board's Final Rule provides for eight bargaining units within acute care hospitals. The Rule makes clear that the eight appropriate units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units mandated by the Rule include: "(1) all registered nurses; (2) all

physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30.

The Rule contains an "extraordinary circumstances" exception which may allow petitions involving bargaining units which are not in substantial accordance with the provisions of the Rule. *See* Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33,932-33 (1988). The Board's "extraordinary circumstances" exception is extremely narrow, however. The Board has stated that it will not consider additional evidence or arguments that a particular hospital varied from the norm, even if the variation is "highly unusual". *Id.* at 33,932. Hospitals bear a "heavy burden" to demonstrate that extraordinary circumstances exist which make application of the Rule inappropriate. *Id.* at 33,933. In particular, the Board has stated that "increased functional integration of and a higher degree of work contacts between, employees as a result of the advent of the multicompetent worker, increased use of 'team' care and cross-training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33,932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. *Id.*

The Board's Final Rule is thus arbitrary and capricious in that its application would ignore the special circumstances of employment within Maryland acute care hospitals and threatens to disrupt the delivery of quality health care at Maryland institutions. Acute care hospital members of the MHA will not have a meaningful opportunity to argue the appropriateness of alternative bargaining units in response to future representation petitions. The Rule is equivalent to an irrebuttable presumption and therefore it is not consistent with the "in each case" requirement of Section 9(b). The harm visited by the Board's Final Rule on acute care hospitals within Maryland can only be avoided by reversal of the Seventh Circuit's decision and reinstatement of the district court's permanent injunction prohibiting implementation of the Rule.

III. ARGUMENT

For over thirteen years, the NLRB determined the appropriateness of bargaining units in acute care hospitals on a case by case basis. In 1987, however, the Board decided to begin rulemaking proceedings to create a uniform rule for determining appropriate bargaining units in the health care industry. On April 21, 1989, the Board issued its Final Rule for determining the appropriateness of bargaining units in acute care hospitals. Instead of rebuttable guidelines for determining bargaining units, the Rule that was created was rigid and inflexible, mandating that only eight specific bargaining units are appropriate for acute care hospitals.

The Petitioner, the American Hospital Association, challenged the Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court issued a permanent injunction barring the enforcement of the Board's Final Rule. *American Hosp. Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule was in conflict with the congressional admonition to give due consideration to preventing proliferation of bargaining units in the health care industry. The court said:

> A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

718 F. Supp. at 716.

Respondents appealed the district court's decision to the Seventh Circuit Court of Appeals. In *American Hosp. Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed the decision of the district court and vacated the injunction. The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case by case determination of bargaining units. The court also held that the Rule was not precluded by the congressional admonition against proliferation of bargaining units in the health care field.

Finally, the court of appeals rejected the American Hospital Association's argument that the Final Rule was arbitrary and capricious because it failed to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 659.

The MHA supports the argument of Petitioner in this case that the Board's Final Rule is contrary to Section 9(b) of the Act, is in conflict with the congressional admonition against proliferation of bargaining units in the health care industry, and is arbitrary and capricious. As will be demonstrated below, the Board's Final Rule ignores significant differences among acute care hospitals in Maryland and requires the creation of arbitrary bargaining units in every health care workplace without providing each health care employer the opportunity to demonstrate that the special conditions of employment at its facility merit deviation from the Board's mandated bargaining units.

A. The Plain Language Of The Act Requires A Bargaining Unit Determination In Each Case

Section 9(b) of the National Labor Relations Act provides in pertinent part:

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, plant unit, or subdivision thereof....

29 U.S.C. § 159(b).

Despite the clear directive in Section 9(b) that the Board must determine an appropriate bargaining unit "in each case", the Board proposes to implement a rule which would make eight bargaining units *per se* appropriate in all acute care hospitals, regardless of their size and the complexity of services offered within each facility. In so doing, the Board has overstepped its rulemaking authority because its new bargaining unit rule is directly in conflict with the plain language in the statute. The Rule irrebuttably presumes that certain bargaining units are appropriate without allowing adjudication of substantive issues impacting the appropriate unit determination or consideration

of specific employment facts in each case. Therefore, the Board's Final Rule must be held to be invalid.

This Court has long held that where the language of an act is plain, it must be enforced according to its terms. *See Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain, ... the sole function of the courts is to enforce it according to its terms."); *see also Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980) ("[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.").

All that is required for giving statutory language its conclusive effect is that Congress' intent be expressed with sufficient precision in the act. *See United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989) (finding that the inquiry into the meaning of § 506(b) of the Bankruptcy Code should begin and end with the language of the statute itself.); *INS v. Cardoza Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring) ("Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent."); *Commissioner of Internal Revenue v. Asphalt Prods. Co.*, 482 U.S. 117, 121 (1987) ("Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided.").

Also, despite the generally held rule of deference to an agency's interpretation of a statute, the Board's discretion and this Court's deference to the Board's interpretation of Section 9(b) "is constrained by [this Court's] obligation to honor the clear meaning of a statute, as revealed by its language, purpose and history". *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The principle of deference to an agency's construction of a statute has no application where the language of the statute is clear. As stated by this Court in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.

Id. at 842.

As explained by the district court in this case, there is "compelling support" in the legislative history of the National Labor Relations Act to construe Section 9(b) in accordance with its plain and unambiguous meaning, i.e., that bargaining unit determinations "require fact specific inquiries". 718 F. Supp. at 710. The Board should not be allowed to circumvent the plain meaning of Section 9(b) by "creating an ambiguity where none exists". *See Escondido Mut. Water Co. v. La Jolla Band of Mission Indians*, 466 U.S. 765, 781 (1984) (rejecting the court of appeals' purported discovery of an ambiguity in Section 4(e) of the Federal Power Act); *United States v. Turkette*, 452 U.S. 576, 580-81 (1981) (rule of *ejusdem generis* has no application where there is no uncertainty as to the meaning of a particular clause in a statute).

The Board's current interpretation of Section 9(b) should also be rejected in light of its prior conflicting interpretations of its statutory obligation to determine a bargaining unit "in each case". Despite its conclusion now that certain "pre-ordained" bargaining units are *per se* appropriate, the Board has stated many times during adjudicatory proceedings that generalizations as to appropriate bargaining units are not appropriate. *See, e.g., Otis Hosp., Inc.*, 219 N.L.R.B. 164, 165 (1975) ("[N]ot all health care institutions may be exactly alike.... Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise."); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980) (holding that the "in each case" requirement of Section 9(b) precluded a *per se* approach to bargaining unit determinations); *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39, 954 (1984) (finding

that the diverse nature of the health care industry precluded any generalizations as to the appropriateness of particular bargaining units and stating: "No unit is *per se* appropriate and ... separate representation must be justified upon each factual record....").

This Court has rejected requests for deference to agency decisions where the position of the agency has been inconsistent. *See INS v. Cardoza Fonseca*, 480 U.S. at 446 n.30 ("An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."). The NLRB has construed "in each case" language in another statute, the Postal Reorganization Act, as requiring case by case determinations of bargaining units. In *United States Postal Serv.*, 208 N.L.R.B. 948, 952-53 (1974), the Board followed its traditional community of interests analysis in considering the appropriateness of certain bargaining units involving the Postal Service. The Board was persuaded to analyze the petitions on a case by case basis by the language of the Postal Reorganization Act which states: "The National Labor Relations Board shall decide in each case the unit appropriate for collective bargaining in the Postal Service...." 39 U.S.C. § 1202. There can be no rational reason for a departure from a case by case analysis of health care industry petitions where the language of Section 9(b) also mandates that bargaining units be determined "in each case".

The "in each case" language of Section 9(b) clearly requires adjudication of particular facts in each case to determine the appropriate bargaining unit or at least a rule regulating bargaining unit determinations that provides a meaningful opportunity for a health care employer in any particular case to demonstrate that the Rule should not be applied to its hospital. The Seventh Circuit's tortured interpretation of Section 9(b) for purposes of approving the Board's Final Rule should be rejected as contrary to the clear meaning of the statute.

B. Implementation Of The Board's Rule Will Deny Hospitals An Opportunity To Be Heard On The Appropriateness Of Any Specific Bargaining Unit Within Their Facilities

As argued above, Section 9(b) of the Act requires the Board to make a bargaining unit determination "in each case". For many years, the Board has utilized a case by case hearing procedure to determine the appropriate bargaining unit in acute care hospitals. Such a procedure guarantees that each hospital will have the opportunity to be heard on the appropriateness of any proposed bargaining unit. *Amicus curiae* contends that only the Board's case by case representation procedures will provide the appropriate opportunity for health care employers to present evidence relevant to the appropriate bargaining unit question. A case by case determination affords employers the right to be heard in a meaningful manner on important bargaining unit issues and is consistent with the mandate of Section 9(b) of the Act.

In contrast, the Board's Final Rule does not afford a health care employer confronted with a petition for representation the opportunity to argue that only certain bargaining units are appropriate because of the special circumstances of employment in its facility. The Board's Final Rule creates a conclusive presumption that only certain units are appropriate. As stated by the Board during its rulemaking proceeding:

> We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers.... Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations....

NPR I, 52 Fed. Reg. 25,142 (1987).

The Board's decision to eschew a rebuttable presumption in favor of a conclusive or irrebuttable presumption creates a rule which is inconsistent with the mandate in Section 9(b) to make bargaining unit determinations "in each case." As argued above, that language mandates consideration of specific facts in each case. Unless interested parties are afforded an opportunity to rebut the presumptions created by the Board's Final Rule, the Board's rulemaking is contrary to the Act and is thus invalid. *See Big Y. Foods, Inc. v. NLRB*, 651 F.2d

40, 45-46 (1st Cir. 1981) (stating that Section 9(b) would invalidate a conclusive presumption because "a conclusive presumption precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees"). The Board has discretion to use rulemaking but only if it is rational and consistent with the Act. *See Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 501 (1978); *see also* Note, *NLRB Guidelines for Determining Health Care Industry Bargaining Units: Judicial Acceptance or Back to the Drawing Board*, 78 Ky. L.J. 143, 158-61 (1989).

The Board's "extraordinary circumstances" exception will not provide an adequate opportunity for individual hospitals to raise issues regarding the appropriateness of any of the mandated bargaining units in their facilities. As mentioned, the Board's extraordinary circumstances exception is extremely narrow. In particular, the Board does not intend to consider increased functional integration between employees or a high degree of work contacts between employees as an extraordinary circumstance meriting relief from the Rule. Similarly, the increased use of team care and cross training of health care professionals which is occurring with increasing frequency in modern acute care hospitals will not be entertained by the Board as an extraordinary circumstance. Differences in the sizes of acute care hospitals, the variety of services offered by each institution, and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. 53 Fed. Reg. 33,932-33 (1988).

Application of the Rule will prevent hospitals like GBMC and Peninsula General from arguing the appropriateness of alternative bargaining units in response to the pending petitions by the MNA. The very factors that make each hospital unique will not be revealed if the Board's new Rule is allowed to be implemented and applied to the pending petitions. For example, the petition for an all RN unit at GBMC will undoubtedly be approved without a specific analysis of employment conditions at GBMC. If the union is successful in convincing registered nurses to vote for representation at GBMC, the hospital will be faced with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at GBMC. The result will be

a fragmentation of the workforce with some professionals working under work rules governed by the collective bargaining agreement while others will be working under the personnel policies of GBMC.

There are many factors which argue in favor of a broader all professional unit at GBMC. The evidence of integration and interaction between registered nurses and other health care professionals at GBMC was presented at the hearing on the bargaining unit issue and need not be repeated in detail here. In brief, however, there are many departments at GBMC where registered nurses are integrated with other health care professionals. For example, registered nurses within the radiology department work with radiology technicians and other allied health care professionals to assist in treatment of patients undergoing intervention radiology. Similarly, in the neonatal unit at GBMC, respiratory therapists work with registered nurses to provide sophisticated care to infant patients within the unit. Operating room procedures at GBMC include a variety of integrated services involving doctors, registered nurses, operating room technicals, laser technicals, pump technicals, and other equipment technicals. In cardiac rehabilitation, physical therapists and registered nurses work together to provide therapy. Registered nurses, dieticians, physicians and pharmacists regularly consult regarding nutrition support issues in an effort to enhance patient care at the hospital. The discharge planner at GBMC is a registered nurse who works with other social workers in advising patients on post-discharge treatment and recovery. Thus, GBMC has substantial evidence of integration between registered nurses and other allied health professionals which should be considered by the Region before it decides that only an all RN unit is appropriate.

In addition to factors demonstrating an integrated professional workforce at GBMC, the hospital also provides identical benefit plans to registered nurses and other allied health professionals. The registered nurses at GBMC share similar education and licensure requirements with other health care professionals. Compensation ranges are comparable for professionals at the hospital. Bonus pay, weekend differential and weekend alternative benefits are paid to allied health professionals as well as registered nurses. Allied health professionals working in direct patient care areas, e.g., respiratory therapists, radiology technologists, and medical technologists often

work the same shifts and get the same percentage differential as registered nurses. Finally, education and training at GBMC is open to coalitions of health care professionals. It is obvious that the specific conditions of employment at GBMC must be considered prior to any determination of an appropriate bargaining unit. As currently structured, the Board's Final Rule with its "extraordinary circumstances" exception will not provide GBMC the opportunity to demonstrate that an alternative bargaining unit is better suited to the special needs of GBMC.

Similarly, if the Seventh Circuit's decision is not overturned, Peninsula General's argument for an all nonprofessional unit will be ignored by Region 5 and the union's petition for a technical unit will be automatically approved without considering the factors which might make such a unit inappropriate. Again, Peninsula General has argued those factors in a hearing before the Board. The Board, however, will not consider the community of interests between technicals and other nonprofessional employees at Peninsula General if the Final Rule is implemented.

Some of the factors which make a bargaining unit of all nonprofessionals appropriate at Peninsula General include identical benefits, uniform personnel policies, similar scheduling, comparable wages, considerable interaction and integration between service, maintenance, and technical employees, numerous transfers between technical and nontechnical categories, and common supervision. At the hearing on the bargaining unit issue, the hospital was able to demonstrate not only integration of technicals and other nonprofessionals *within* departments (e.g., technical and other nonprofessional members of the nursing team may check vital signs, maintain records, provide colostomy care, transfer patients, feed patients, ambulate patients, secure patient medical records, implement patient safety measures, facilitate performance of diagnostic tests, order medication, and generate documentation of patient care and charges) but also integration of technicals and other nonprofessionals *between* departments.[3]

[3] The detailed information regarding integration and interaction between technicals and nonprofessionals at Peninsula General was culled from Peninsula General's "Brief to the Regional Director on Behalf of Peninsula General Hospital" in Case No. 5-RC-13356.

For example, dietary clerks from the food and nutrition services department at Peninsula General tabulate daily menus which are collected from patients by members of the nursing team. Nursing assistants help patients to understand menu selections. Nursing team members, including licensed practical nurses and nursing assistants, communicate physicians' orders regarding specific dietary needs of patients to the dietary staff. Environmental services employees communicate with nursing staff before cleaning rooms to determine whether special precautions are required. Environmental services personnel also provide special cleaning that is required in operating rooms and delivery rooms and coordinate their functions with technical and nonprofessional staff assigned to these areas. Maintenance employees must coordinate their efforts with personnel in patient care and diagnostic areas. Physical therapy aides who assist in transporting patients must interface with members of the nursing team to obtain necessary medical records for documenting the care being provided to patients. Nontechnical members of the nursing team assist technical employees from the lab in drawing blood specimens from difficult or uncooperative patients.

The hospital was also able to demonstrate extensive common supervision at the hearing by showing that forty-two technical and other nonprofessional job classifications had shared supervision. Evidence at the hearing supported the hospital's comparable salary argument in that 129 separate technical and other nonprofessional job classifications shared the same starting rate.

Thus, Peninsula General has made a substantial showing of common interests between technicals and other nonprofessionals in the hearing before the NLRB. The hospital's efforts in this regard will be for naught, however, if the Final Rule is implemented by the Board. The Board's narrow extraordinary circumstances exception will not allow consideration of the factual record established by Peninsula General at the representation hearing. The petition for a technical unit will be approved without consideration of the many factors which militate against adoption of such a unit.

The immediate harm that will result to acute care hospitals as a consequence of the Board's decision to abandon case by case adjudication and resort to a *per se* rule regarding bargaining units is

obvious with hospitals like GBMC and Peninsula General. They are interested parties to representation proceedings yet the Board's Rule will effectively prohibit them from presenting any evidence which might rebut the Board's presumption that only certain bargaining units are appropriate. In these cases, the Rule will have an immediate impact. It can be seen, however, that the proliferation of bargaining units fueled by the Board's Rule and the consequent impact on administrative costs at other hospitals within Maryland also make the Final Rule unjustifiable.

C. The Board's Rule Ignores The Congressional Admonition Against Undue Proliferation Of Bargaining Units In The Health Care Industry

Hospitals within Maryland must regulate their labor relations policies in accordance with the National Labor Relations Act as interpreted by the National Labor Relations Board *and* as enforced by the United States Court of Appeals for the Fourth Circuit. The Fourth Circuit requires each bargaining unit determination of the NLRB to reflect the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). In *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191 (4th Cir. 1982), the NLRB sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The court of appeals rejected the Board's findings because the NLRB did not give due consideration to the issue of proliferation of bargaining units at the hospital. 691 F.2d at 194.

The underlying decision of the Board, *Frederick Memorial Hosp., Inc.*, 254 N.L.R.B. 36 (1981), had upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interest, separate and apart from all other professionals, to justify their own unit for bargaining purposes. The NLRB rejected, however, language in the Regional Director's decision which suggested that the RN unit sought by the union was "*per se* appropriate". The Board stated:

> We do not rely on, however, any comments in the Regional Director's decision that may be taken as a conclusion that the registered nurse unit sought here was *per se* appropriate. Our conclusion on the appropriateness of the unit is based on *the particular circumstances involved here*.

Id. at 39 n.12 (emphasis added).

The Court of Appeals for the Fourth Circuit approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

> The Board may not depend solely on the traditional community of interest test when making a unit determination for health care institution employees. As other courts have held, the Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination ... implement[s] or reflect[s] that admonition...."
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> ...
>
> A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the court adequately review the Board's decision and order unless the Board clearly discloses why certific tion of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194 (citations omitted).

The Fourth Circuit recognized in its *Frederick Memorial Hosp.* decision that a unit of registered nurses might not be appropriate in

other hospitals. In this respect, the Fourth Circuit's opinion is clearly at odds with the Seventh Circuit's decision sanctioning the Board's new *per se* approach for bargaining unit determinations. Similarly, the Fourth Circuit requires consideration of the congressional admonition against proliferation in each unit determination and a specific explanation of why certification of a particular unit in each case serves the congressional admonition against unit proliferation. This holding of the Fourth Circuit is again clearly at odds with the Seventh Circuit's decision. *See American Hosp. Ass'n v. NLRB*, 899 F.2d at 658 ("[The admonition] is cautionary rather than directive.").

The Fourth Circuit's recognition of the importance of adhering to the congressional admonition against proliferation is shared by other courts of appeals. *See, e.g., Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632 (2d Cir. 1983); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *St. Anthony Hosp. Sys., Inc. v. NLRB*, 884 F.2d 518, 519-20 & n.3 (10th Cir. 1989). Such an approach to bargaining unit determinations is preferred over the abdication of responsibility for proliferation exemplified by the Seventh Circuit's treatment of the NLRB's Final Rule in this case. It is the district court in this case which correctly concluded that the Board by "designat[ing] an absolute number of appropriate units and mandat[ing] a particular division of the workforce was not responsive to Congress' express concern". 718 F. Supp. at 716.

D. The Board's Rule Will Promote A Proliferation Of Organized Units Within Acute Care Hospitals And Multiply Costs For Hospitals Already Faced With Financial Difficulties

The Board's Rule could not have come at a worse time for acute care facilities within Maryland. A recent financial report issued by the MHA reveals that forty-two percent of Maryland hospitals suffered operational losses in the twelve month period ending June 30, 1990, as compared with thirty-seven percent the previous year. Twenty-nine percent of the hospitals incurred losses from operations in both 1989 and 1990. The MHA's report follows on the heels of a February, 1990 report of the Maryland Health Services Cost Review Commission which describes the financial performance of Maryland hospitals

during 1989 as "generally negative - operating and total profits are down - return on total assets is essentially unchanged, and long-term debt has increased".[4]

The Board has stated that it did "carefully consider the Congressional admonition against proliferation" during its rulemaking proceeding and it maintains that its Rule mandating eight units does demonstrate a concern for proliferation. NPR II, 53 Fed. Reg. 33,933. It does not appear, however, that the Board examined the *costs* of proliferation to acute care hospitals when it decided to move away from its conclusion in *St. Francis Hosp.*, 271 N.L.R.B. 948 (1984), that only a broad professional bargaining unit and a broad nonprofessional unit are appropriate within acute care hospitals unless a smaller unit is justified on the basis of the Board's disparity-of-interests test.

There are eleven acute care hospital members of the MHA which currently have employees represented by unions. The administration and negotiation of collective bargaining agreements with these unions obviously create additional costs for each hospital. Administrative costs are substantial even where there is only one organized unit at a facility. For example, Greater Baltimore Medical Center has assigned one full time equivalent to the administration of its contract with District 1199E. The Director of Personnel also devotes substantial time to the administration of the hospital's contract with the representative of the hospital's service and maintenance employees. The hospital estimates that approximately $55,000 in direct labor costs are devoted exclusively to administration of the union agreement.

Other Maryland hospitals are likewise incurring extensive costs in administering union agreements at their facilities. For example, Bon Secours Hospital's service and maintenance employees are rep-

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[4] The MHA report showed that the average operating margin of hospitals in Maryland fell from 1.0 percent to 0.9 percent. The study also showed that Maryland hospitals experienced a net profit decline of $7 million. *See* Financial Condition Report, Second Quarter, Maryland Hospital Association Information Services, No. 10, 1990. The Maryland Health Services Cost Review Commission is responsible for monitoring hospital charges within Maryland. Its February, 1990 report shows that Maryland hospitals had an operating margin of just .38 percent in 1989, down from .88 percent in 1988. *See* Report on the Financial Condition of Maryland Hospitals, Health Services Cost Review Commission (Feb. 1990).

resented by Hospital Employees Local No. 1273, an affiliate of the Laborers International Union. Bon Secours' administrative costs have increased because of substantial differences in the union's health insurance plan and the hospital's program, including differences in benefits and procedures under each plan. The hospital also reports that eligibility for leave is different for union and nonunion employees. Vacations and holidays differ for each group. Internal grievance procedures must be administered differently for union and nonunion employees.

Contract negotiations with Local 1273 also substantially increase the hospital's administrative costs. The most recent negotiations with Local 1273 involved eight sessions lasting approximately eight hours each day. Five members of management sit on the negotiating committee with a sixth person available for benefits consultation. The hospital brings an attorney in for the final bargaining session which again adds to the cost of negotiations. The hospital estimates that it expended at least $13,000 during its contract negotiations with Local 1273. This estimate does not include the hospital's preparation for negotiations which includes meetings with all department managers.

A strike plan is also developed at Bon Secours when negotiations begin on a new contract and such preparations again are time consuming and costly. Strike planning involves all 35 department heads, upper management, the COO of the hospital and the personnel manager. The hospital estimates that there are 80-90 hours involved in strike planning. During its most recent negotiations with the union, the hospital received a § 8(g) notice which obviously enervated the hospital's contingency plan for strikes. Finally, Bon Secours Hospital estimates it may spend 50-55 hours in implementing the new contract. Personnel must meet with managers to explain any changes in the new agreement and there is additional administrative time involved with implementing the details of new economic provisions.

The Johns Hopkins Hospital has also devoted substantial time and resources to administering its service and maintenance unit contract with District 1199E. It estimates that the direct salary cost of administration of the contract in 1990 will be at least $50,000. This cost estimate includes salaries for Human Resources personnel only.

It does not include the cost of administering the benefits component of the contract or administrative costs relating to the involvement of nursing directors and other managers within the hospital. Negotiations over the agreement require additional costs including legal fees. There are eight people on the negotiating team and each negotiation requires extensive preparation. The hospital estimates its total expenditures during a year when negotiations occur are at least twice that of a normal year.

Sinai Hospital also has a contract with District 1199E which covers its service and maintenance employees. The hospital estimates its annual costs for administering the contract to be approximately $38,000 a year. During contract negotiations, the Director of Personnel becomes heavily involved in preparing for and participating in the negotiations. The cost of the director's time which is devoted to the negotiations is approximately $10,000. The total cost for negotiations is substantially more, however, because the Vice President of Employee Relations also gets involved in the negotiations. Preparations for contract negotiations begin four to five months before the contract actually expires. The negotiating team conducts eight to ten meetings with its department heads to develop a consolidated approach to the negotiations. Thus, there is substantial time devoted to negotiation issues by individuals who are not actually part of the negotiating team. Sinai Hospital also prepares a strike contingency plan which involves the collective input of ten to fifteen people including the Vice President of Employee Relations and various department heads. All of this effort must be factored into any analysis of costs for the hospital.

The Francis Scott Key Medical Center in Baltimore has a contract with AFSCME which represents its service and maintenance employees including maintenance employees, nursing aides, housekeeping employees, food service employees, some technicals within the hospital and geriatric nursing assistants. Preparations for negotiations at the medical center begin some six to seven months before the start of talks with the union. The preparation involves the Vice President of Human Resources and two members of her staff. The negotiating team includes representatives from nursing, a representative from the nursing home, a joint housekeeping and dietary administrator, the Employee Relations Manager, the Vice President

of Human Resources and outside counsel. Prior to actual negotiations, the negotiating team will spend almost two weeks finalizing negotiating strategy and examining contract demands. Initial preparation by the team, excluding attorneys' fees, averages about $8,000 per week. The negotiations usually involve ten to twelve meetings with the union. The hospital estimates its costs for actual negotiations could be as much as $32,000.

Finally, employees at Prince George's Hospital Center in Cheverly, Maryland, are represented by three different collective bargaining representatives. The Professional Staff Nurses Association represents registered nurses, assistant head nurses, instructors and clinical specialists. Hospital Employees Local 63, International Brotherhood of Firemen and Oilers, represents service, clerical and maintenance employees and licensed practical nurses. PG House Staff Associates represents interns and residents at the hospital. To complicate matters, District 1199E has petitioned the NLRB to represent hospital technicals at Prince George's Hospital Center who are not covered under the Local 63 contract.

Prince George's Hospital Center is a part of Dimensions Health Corporation. The corporation uses the same core team of negotiators for negotiating the contracts with Local 63 and the nurses union but each contract is negotiated separately. Staff salary costs of the negotiating team involved in the negotiations amount to almost $2000 a day. The bargaining team includes the Senior Vice President of Human Resources, the assistant administrators for human resources of the hospitals in the corporation, and other appropriate administrators. The corporation has scheduled fifteen full days for its reopener negotiations with the nurses union and costs could run over $30,000 for these negotiations. This figure does not cover the cost of replacing the nurses sitting across the table from the hospital administrators for eight hours a day during the negotiations. The hospital must pay both the nurses on the union's negotiating team and their replacements at each facility.

At Prince George's Hospital Center, the basic salary cost for administering the three separate contracts is $60,000 a year. This estimate includes only the time of the assistant administrator and the employee relations officer. It does not include the salary cost of the

other managers and executives who must be involved in resolving contract interpretation issues, grievance resolution hearings, ongoing meetings with union leadership and follow-up meetings with the department managers and executives. The hospital estimates that these additional salary expenses could be as much as $200,000 a year. If the hospital has to go to arbitration with any of the unions, outside counsel is generally involved. Costs then accelerate rapidly because of attorneys' fees.

Preparation for negotiations at Prince George's Hospital Center occurs on several levels. There are meetings between top executives and financial officers where top level management examine the hospital's financial condition and its negotiating strategies for meeting bottom line financial costs. At another level, there are general discussions between the negotiating team and the hospital's senior managers regarding the goals of the hospital during the negotiations. At a third level, there is interaction with sixty department managers to review issues relating to the administration of the old contract and what changes should be made.

Limitations in each union agreement make administration of Prince George's Hospital Center substantially more difficult. Even though there are similar provisions in the contracts, all three groups have separate grievance procedures. Shift differentials and weekend differentials all vary in extent and scope. On call rules also vary which complicate department managers' efforts at operating departments efficiently. There are restrictions on reassignment of employees. Obviously, more avenues for contract violations are open because the hospital is dealing with three separate units and the possibility of inadvertent misapplication of policy. Payroll is an administrative nightmare with different pay policies and scales as well as differences in accrual of vacation time and leave options.

Negotiations with unions and the administration of union contracts create substantial costs for each Maryland hospital which has any organized bargaining units. These costs do not include the disruption which can occur from strikes or from preparation for strikes. Many of the hospitals with unions report that they regularly receive § 8(g) notices during negotiations. Even during organizing, hospitals are subject to work stoppages. A recognitional strike can shut down

a hospital as effectively as a strike over economic matters during negotiations.

The Board's Final Rule with its provision for eight different bargaining units is a catastrophe for union and nonunion hospitals alike. Those hospitals which are already experiencing increased costs from administering and negotiating one or more contracts with unions have no doubt that the Board's new Rule will multiply those costs should other units within their hospitals become organized. Other hospitals will eventually be affected by the Rule because unions are poised to take advantage of the prescription for proliferation which is built into the structure of the Final Rule.[5]

The Board's Rule ignores the increase in costs which will be visited upon hospitals after implementation of the *per se* bargaining unit rule. The impact of proliferation cannot be measured simply by counting the number of hospital units that ultimately might be created by operation of the Final Rule. Even the addition of one unit could place a serious burden on hospitals already substantially burdened with costs associated with negotiating and administering union agreements. The administrative costs outlined above could be doubled, tripled or, in the worst case scenario, octupled by operation of the Board's Rule. Instead of having to administer a broad service and maintenance unit with just one union, hospitals organized under the new Rule may have to negotiate with three different unions and administer three separate contracts. The Board has given short shrift to the congressional admonition against proliferation and hospitals in Maryland will pay the consequences.

E. The Board's Rule Is Arbitrary And Capricious Because It Applies To All Hospitals In Maryland Regardless Of Their Size And The Diversity Of Services Offered At Each Facility

[5] The National Union of Hospital and Health Care Employees recently announced that it would triple its 28,000 member dues in order to finance a massive, nationwide organizing campaign in 1991. The union expects this Court to approve the Board's Final Rule and, in response, it will add 400 more organizers to undertake what the union calls "the largest mobilization for organizing ever undertaken by the American labor movement." *See* 213 Daily Labor Report (BNA) at p. A-18 (11-2-90).

The Board has concluded that its Final Rule should apply to all acute care hospitals regardless of hospital size and the variety of services offered by individual institutions. While conceding that the health care industry is comprised of a "multiformity of individual constituent institutions", the Board attempted to justify the application of a *per se* rule to all hospitals by dismissing the differences among acute care hospitals as merely "minor differences". *See* NPR II, 53 Fed.Reg. 33,932. To describe the diversities in health care facilities as only minor differences is extremely myopic. The Board's decision to apply the Rule to all acute care hospitals is arbitrary and capricious because it ignores the impact of size and the complexity of services within each facility on the community of interests of employees at each facility.

Member hospitals within the MHA are extremely varied in size. For example, Johns Hopkins has over 6,000 employees and 952 beds while a rural hospital like Kent & Queen Anne's Hospital has 300 employees and only 64 beds. Johns Hopkins' operating budget is over 20 times greater than the operating budget of Kent & Queen Anne's Hospital. App., *infra*, p. 6a. Johns Hopkins has over 1,500 registered nurses while Kent & Queen Anne's Hospital employs approximately 80 registered nurses. Similarly, the University of Maryland Medical System ("UMMS") in Baltimore, Maryland, has 747 beds while the Edward W. McCready Memorial Hospital ("McCready Memorial") in Crisfield, Maryland, has 41 beds.

Size is not the only difference between large urban institutions like Johns Hopkins and UMMS and smaller rural hospitals within Maryland. Johns Hopkins and UMMS are tertiary care facilities with many departments providing specialized care to patients with severe injuries and illnesses. Health care professionals assigned to these specialty units are likely to have more in common with each other than with similarly licensed professionals within the hospital. For example, registered nurses assigned to the oncology department within Johns Hopkins are likely to have more in common with the social workers in the department than with registered nurses in other departments of the hospital. Similarly, health care professionals in the shock trauma center at UMMS or in the cancer center will undoubtedly have special interests arising out of their employment in such tertiary care units which would undercut the assumptions underlying the Board's

per se rule. Nurses within the neonatal unit at St. Agnes Hospital may have more in common with the doctors, respiratory therapists and physical therapists working in the unit than with nurses providing general patient care at St. Agnes. The Board's assumption that registered nurses all have similar working conditions and interests is extremely naive when viewed in the context of large metropolitan hospitals with specialized units.

In contrast, rural hospitals like Kent & Queen Anne's Hospital and McCready Memorial are much smaller community hospitals. Although each hospital provides quality care to its patients, it does not have the resources to staff and equip a tertiary care unit. Thus, registered nurses within smaller hospitals may in fact have similar duties. Nevertheless, the smaller size of these hospitals increases the integration and interaction between nurses and other allied health professionals throughout the hospital. This is also true of service and maintenance employees in a small hospital. The limited resources of the smaller hospital may require employees to perform a number of different service and maintenance functions which make the Board's mandated division of service and maintenance employees into a technical unit, a skilled maintenance unit and a nonprofessional employee unit arbitrary and capricious as it is applied to a smaller facility.

The Board's Rule also ignores the differences between professionals in psychiatric units or rehabilitation units within acute care hospitals. The Board has stated that to the extent that the acute care hospitals have psychiatric sections, these hospitals are not excluded from the application of the Rule unless the psychiatric sections predominate. 53 Fed. Reg. 33,930. Thus, registered nurses working within psychiatric units at acute care hospitals would be included in the RN unit even though they are giving more specialized care to patients than registered nurses working with patients in the general treatment areas of the hospital. Similarly, the Rule ignores hospitals which have rehabilitation units. In rehabilitation departments, social workers, physical therapists, occupational therapists, psychologists and registered nurses all work together to help patients with traumatic injuries cope with the necessary changes in their life style. The Rule mandates that nurses within such a unit be set apart from other professionals in an all RN bargaining unit regardless of the similarities

in terms and conditions of employment between these nurses and other allied health professionals in the rehabilitation unit.

The Board's rationale for adopting its Final Rule for acute care hospitals makes even less sense when it is contrasted with the Board's stated reasons for excluding nursing homes from the application of the Rule. The Board concluded that the Rule should not apply to nursing homes because there were not only substantial differences between nursing homes and hospitals but "*significant differences between the various types of nursing homes which affect staffing patterns and duties*". 53 Fed. Reg. 33,928. The Board said:

> In the absence of a measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units.... We therefore conclude that it is best to continue a case by case approach with respect to nursing homes."

Id. at 33,928-33,929.

It is amazing that the Board found differences between nursing homes to be significant enough to merit continuation of the case by case unit determination process while the many differences between acute care hospitals were deemed to be "minor" differences. The Board's reasoning is arbitrary and capricious in this respect and will only result in disruption and upheaval in acute care hospitals if the Rule is allowed to be implemented.

F. The Board's Rule Is Arbitrary And Capricious Because It Ignores The Integration And Interaction Of Health Care Employees Within Maryland Hospitals

The Board's Final Rule ignores the trend toward increased integration of professionals in Maryland hospitals. The Rule ignores the increased focus on team care within Maryland hospitals and established mechanisms for collaborative care within each hospital. The examples of such interdisciplinary concepts for patient care and the integration of professionals within Maryland hospitals are numerous. The Final Rule, however, will not allow any hospital to demonstrate that its team approach to health care makes the Board's mandated bargaining units inappropriate for its facility.

Hospitals within Maryland almost uniformly utilize various strategies for collaborative care of patients within their facilities. Whether the planning device or concept is labeled "critical path", "collaborative committee for patient care", or "interdisciplinary committee on patient care", the result is the same: a team approach to patient care at the hospital. From the moment the patient enters the hospital, a plan begins to take shape for effective and efficient care during the patient's stay at the hospital. Physicians, registered nurses, dietitians, pharmacists, social workers, and other allied health professionals coordinate their efforts and implement an integrated method for dealing with the patient's illness. Patients with unique illnesses or injuries may be scrutinized by an interdisciplinary study group. Quality assurance is also a coordinated program with extensive interaction between health care professionals.

Many hospitals utilize nutrition support teams to supplement the patient care plan. Doctors, registered nurses and dieticians meet and discuss nutritional support for enhancing and accelerating the patient's recovery. Pharmacists are also consulted so that the patient's diet is compatible with prescribed medicines. Doctors may order a special nutritional assessment to determine the nutritional needs of a patient with the result that dieticians and the nursing staff must evaluate the patient's diet and eating habits.

At the conclusion of a patient's stay, many Maryland hospitals will have facilitated resolution of specific issues relating to the patient's discharge with the help of discharge planning teams. These teams usually involve physicians, social workers, registered nurses and pharmacists who advise patients upon their departure from the acute care facility and help transition them to complete recovery.

Patients in Maryland hospitals are also likely to be exposed to many health care professionals during their stay at the hospital. Patients care areas will be visited by physicians, registered nurses, respiratory therapists, phlebotomists, pharmacists and social workers. Social workers and mental health counselors will be asked to intervene in cases involving child or spousal abuse. A hospital may use "rounds", clinical care committees, or more informal discussion groups to chart and enhance patient progress.

Other departments within acute care hospitals demonstrate the integration and interaction of health care professionals. Delivery of emergency care is very much a team effort with nurses, physicians and x-ray technologists treating the same patients. Operating rooms have historically utilized teams of professionals to provide surgical expertise. With increasing frequency, pharmacists are assigned to nursing units in various satellite pharmacies to increase coordination and delivery time of medicine to hospital patients. Pharmacists may also input the doctors' orders regarding medication and counsel patients regarding the medicines they will be taking. It is not uncommon for registered nurses to be working in labs with medical technologists, in cardiovascular services departments along side cardiovascular technologists, in rehabilitation units with physical therapists and occupational therapists, in mental health units with mental health counselors and social workers, or in radiology departments with x-ray technicians.

The integration and interaction of health care professionals are very important factors that should be explored by the Board before it applies its arbitrary bargaining unit rule to isolate registered nurses from other health care professionals in an otherwise integrated workplace. A case by case adjudication of appropriate bargaining units would reveal that health care professionals in Maryland hospitals participate in common benefit plans and work under uniform personnel policies. They have comparable salaries, receive identical bonus pay, work similar schedules, and receive identical shift differential.

Interdisciplinary training is accomplished through collaborative practice groups. Health care professionals work together on various hospital committees and may give in-service training to each other in their respective specialties. Interaction of employees is stimulated further by training sessions on more generic subjects such as infection control, CPR training, stress management, hazard abatement, or EAP opportunities.

Health care professionals in acute care hospitals in Maryland cannot be collated and sorted into different "pigeon holes". An interdisciplinary approach to patient care is alive and well in Maryland and the Board's Final Rule, with its extremely narrow "extraordinary circumstances" exception, simply does not allow the similarities in

wages, hours and working conditions of hospital personnel to be revealed. The Board should continue its case by case approach (just as it plans to do for other industries), so that the special circumstances of employment for health care personnel can be illuminated "in each case".

IV. CONCLUSION

For all the foregoing reasons, and for the reasons stated in the brief of the American Hospital Association, the decision of the Seventh Circuit should be reversed.

Respectfully submitted,

By:_____

JOHN G. KRUCHKO*
PAUL M. LUSKY
KRUCHKO & FRIES
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204
(301) 321-7310

Attorneys For Amicus Curiae
The Maryland Hospital
Association, Inc.

*Counsel of Record

APPENDIX

U.S. Department of Justice
Office of the Solicitor General

October 24, 1990

Paul M. Lusky
Kruchko & Fries
Counselors at Law
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

Re: *American Hospital Association* v. *NLRB*
No. 90-97

Dear Mr. Lusky:

In response to your letter of October 23, 1990, I hereby consent to the filing in the above-captioned case of an *amicus curiae* brief on behalf of the Maryland Hospital Association.

Sincerely,

/s/ Kenneth W. Starr
Solicitor General

Dickstein, Shapiro and Morin

October 24, 1990

Paul M. Lusky, Esquire
Kruchko & Fries
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

RE: *American Hospital Association v. N.L.R.B.*, et al.
No. 90-97

Dear Mr. Lusky:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of the Maryland Hospital Association.

Sincerely,

/s/ Woody N. Peterson

WNP:hmp

American Federation of Labor and Congress of Industrial Organizations

October 29, 1990

Mr. John G. Kruchko
Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive
McLean, Virginia 22102

Dear Messrs. Kruchko & Lusky:

Re: *American Hospital Association v. NLRB, et al.*
(Supreme Court No. 90-97)

The American Federation of Labor and Congress of Industrial Organizations hereby consents to the timely filing of an *amicus curiae* brief in support of the petitioner in the above-referenced matter on behalf of the Maryland and Virginia Hospital Associations.

Sincerely yours,

/s/ David M. Silberman
Associate General Counsel

Mayer, Brown and Platt

October 17, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association* v. *NLRB*

Dear Mr. Lusky:

On behalf of the American Hospital Association, I hereby consent to the filing of a brief *amicus curiae* by the Fairfax Hospital System, et al. in the above-referenced case.

Sincerely,

/s/ James D. Holzhauer

JDH:cml

MARYLAND HOSPITALS CHART[1]

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Anne Arundel Medical Center Annapolis, MD	1782	303	$58,787,400	U
Bon Secours Hospital Baltimore City, MD	980	192	39,744,000	U
Children's Hospital & Center for Reconstructive Surgery Baltimore City, MD	323	68	13,076,900	U
Church Hospital Baltimore City, MD	999	216	44,838,000	U
Francis Scott Key Medical Center Baltimore City, MD	2200	564	78,092,500	U
Franklin Square Hospital Center Baltimore City, MD	2313	427	89,553,300	U
Good Samaritan of Maryland Baltimore City, MD	1211	238	46,583,500	U
Greater Baltimore Medical Center Baltimore County	2200	352	93,858,200	U
Harbor Hospital Center Baltimore City, MD	1377	283	$68,996,500	U

[1] Figures were derived from the most recent data supplied by the Maryland Health Services Cost Review Commission and, when possible, from data supplied by individual hospitals.

[*] The characterization of hospitals as "Urban" in this appendix parallels the designation "Metropolitan" used by the Maryland Health Services Cost Review Commission in its data.

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Homewood Hospital Center Baltimore City, MD	1055	267	61,035,700	U
James Lawrence Kernan Hospital	299	66	12,723,900	U
Johns Hopkins Hospital Baltimore City, MD	6125	952	257,584,900	U
Liberty Medical Center Baltimore City, MD	811	282	47,733,900	U
Maryland General Hospital Baltimore City, MD	1250	213	55,368,500	U
Mercy Medical Center Baltimore City, MD	1319	290	65,466,800	U
Sinai Hospital of Baltimore Baltimore City, MD	2700 FTE	467	125,923,300	U
St. Agnes Hospital of the City of Baltimore Baltimore City, MD	2800	430	93,370,600	U
Union Memorial Hospital Baltimore City, MD	1881	349	88,364,600	U
University of Maryland Medical System Baltimore City, MD	3160	669	211,603,000	U
Suburban Hospital Bethesda, MD	1600	282	61,389,600	U

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Dorchester General Hospital Cambridge, MD	363	114	14,511,900	R
Kent & Queen Anne's Hospital Chestertown, MD	300	64	10,543,000	R
Prince George's Hospital Center Cheverly, MD	1800	423	85,227,800	U
Southern Maryland Hospital Clinton, MD	1092	308	54,267,600 (1988)	U
Howard County General Hospital Columbia, MD	1109	194	41,251,000	U
Edward W. McCready Memorial Hospital Crisfield, MD	200	41	4,279,900	R
Memorial Hospital & Medical Center Cumberland, MD	1100	214	37,144,100	R
Sacred Heart Hospital Cumberland, MD	1022	240	33,875,200 (1988)	R
Memorial Hospital Easton, MD	1000	201	31,947,000	R
Union Hospital of Cecil County Elkton, MD	619	139	25,272,600	R

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Fallston General Hospital Fallston, MD	662	152	25,377,500 (1988)	U
Frederick Memorial Hospital Frederick, MD	1338	235	45,385,700	R
Frostburg Community Hospital Frostburg, MD	148	47	5,430,000	R
North Arundel General Hospital Glen Burnie, MD	1304	285	51,335,700	U
Washington County Hospital Hagerstown, MD	1706	304	57,281,700	R
Harford Memorial Hospital Havre De Grace, MD	610	205	23,413,800 (1988)	R
Physicians Memorial Hospital La Plata, MD	448	104	19,078,300	R
AMI Doctors' Hospital Lanham, MD	880	250	51,657,800	R
Greater Laurel Beltsville Hospital Laurel, MD	738	184	28,733,500	U
St. Mary's Hospital Leonardtown, MD	447	107	18,139,200	R
Garrett County Memorial Hospital Oakland, MD	323	76	10,964,600	R

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Montgomery General Hospital Olney, MD	1045	229	39,079,900	U
Calvert Memorial Hospital Prince Frederick, MD	400	157	18,803,200	R
Baltimore County General Hospital Randallstown, MD	1325	220	47,262,600	U
Leland Memorial Hospital Riverdale, MD	416	107	18,700,200 (1988)	U
Shady Grove Adventist Hospital Rockville, MD	1371	233	54,539,800 (1988)	U
Peninsula General Hospital Medical Center Salisbury, MD	1767	360	68,838,100	R
Holy Cross Hospital of Silver Spring Silver Spring, MD	2000	452	87,002,700	U
Washington Adventist Hospital Takoma Park, MD	1487	300	70,995,700 (1988)	U
St. Joseph Hospital Towson, MD	2045	415	89,913,100	U
Carroll County General Hospital Westminster, MD	882	118	25,080,800	R

MARYLAND HOSPITALS WITH COLLECTIVE BARGAINING UNITS

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Bon Secours Baltimore City, MD	Hospital Employees Local Union No. 1273, District Council of Baltimore & Vicinity, Laborers' International Union of North America, AFL-CIO	Service, maintenance, some clerical employees
Greater Baltimore Medical Center Baltimore County, MD	District 1199-E, National Union of Hospital & Health Care Employees - SEIU	Service and maintenance employees
Greater Laurel-Beltsville Hospital Laurel, MD	Maryland Nurses Association, Staff Nurses Professional Chapter	RNs, assistant head nurses, instructors, clinical specialists
	Hospital Employees Local 63, International Brotherhood of Firemen & Oilers, AFL-CIO	Service, clerical, maintenance employees, LPNs
Johns Hopkins Hospital Baltimore, MD	District 1199-E, National Union of Hospital & Health Care Employees - SEIU	Service and maintenance employees

MARYLAND HOSPITALS WITH COLLECTIVE BARGAINING UNITS (continued)

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Howard County General Hospital Columbia, MD	Local 27, United Food and Commercial Workers Union	RNs
	Local 27	Nonprofessional employees
Francis Scott Key Medical Center Baltimore City, MD	American Federation of State, County, and Municipal Employees, Council 67 and Local 44	Service and maintenance employees, LPNs
Liberty Medical Center Baltimore City, MD	District 1199-E, National Union of Hospital & Health Care Employees - SEIU	Service and maintenance employees, LPNs
	Maryland Nurses Association	RNs, on-call float pool nurses
Maryland General Hospital Baltimore City, MD	District 1199-E, National Union of Hospital & Health Care Employees-SEIU	Service and maintenance employees

MARYLAND HOSPITALS WITH COLLECTIVE BARGAINING UNITS (continued)

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Physicians Memorial Hospital La Plata, MD	Southern Maryland Healthcare Employees Association, Local 1182, Service Employees International Union, AFL-CIO	RNs and LPNs
Prince George's Hospital Center Cheverly, MD	Maryland Nurses Association, Staff Nurses Professional Chapter	RNs, assistant head nurses, instructors, clinical specialists;
	Hospital Employees Local 63, International Brotherhood of Firemen & Oilers, AFL-CIO	Service, clerical and maintenance employees, LPNs;
	PG House Staff Associates	Interns, Residents and Fellows
Sinai Hospital of Baltimore Baltimore City, MD	District 1199-E, National Union of Hospital & Health Care Employees-SEIU	Service and maintenance employees